Senate

General Assembly

File No. 340

February Session, 2010

Substitute Senate Bill No. 233

Senate, April 7, 2010

The Committee on Public Health reported through SEN. HARRIS of the 5th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING THE DISCHARGE OF PATIENTS FOR NONPAYMENT OF APPLIED INCOME.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (b) of section 19a-535 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2010*):

(b) A facility shall not transfer or discharge a patient from the facility **[**except**]** unless (1) the transfer or discharge is necessary to meet the welfare of the patient which cannot be met in the facility, **[**or unless**]** (2) the patient no longer needs the services of the facility due to improved health, **[**or**]** (3) the health or safety of individuals in the facility is endangered, **[**or**]** (4) in the case of a self-pay patient, for his nonpayment or arrearage of more than fifteen days of the per diem facility room rate, **[**or**]** (5) the facility ceases to operate, or (6) to the extent permitted by federal law, the patient has failed to pay to the facility the amount of applied income determined in accordance with the methodology established by the Department of Social Services for

recipients of medical assistance for more than sixty days. In each case the basis for transfer or discharge shall be documented in the patient's medical record by a physician. In each case where the welfare, health or safety of the patient is concerned the documentation shall be by the patient's physician. A facility which is part of a continuing care facility which guarantees life care for its residents, as defined in subsection (b) of section 17b-354, may transfer or discharge **[**(1)**]** (A) a resident self-pay patient who has intentionally transferred assets in a sum which will render the patient unable to pay the costs of facility care in accordance with the contract between the resident and the facility or **[**(2)**]** (B) a nonresident self-pay patient who has intentionally transferred assets in a sum which will render the patient unable to pay the costs of a total of forty-two months of facility care from the date of initial admission to the facility.

Sec. 2. (NEW) (*Effective October 1, 2010*) Each facility, as defined in subsection (a) of section 19a-535 of the general statutes, shall provide each patient who has applied for medical assistance with the Department of Social Services an estimate of the amount of the patient's applied income determined in accordance with the methodology established by said department for recipients of medical assistance. Each facility shall provide a written notice to each such patient, as evidenced by the patient's written acknowledgment, containing such estimate and a statement informing the patient that failure to pay applied income to the facility may result in the patient's transfer or discharge from the facility pursuant to section 19a-535 of the general statutes, as amended by this act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2010*	19a-535(b)
Sec. 2	*October 1, 2010*	New section

AGE *Joint Favorable Subst. C/R* PH

PH *Joint Favorable*

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect
Department of Social Services	GF - Potential Cost

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill allows nursing homes to discharge or transfer Medicaid patients who have not complied with their "applied income" payment requirements. The bill does not specify where the patient is to be located after the transfer or discharge. As it is unlikely that another nursing home would accept a patient that has not complied with their payment requirements, it is assumed that these patients would eventually be placed in an acute inpatient hospital. As Medicaid per diem costs for hospitals exceed those for nursing homes, the state would incur additional costs. The extent of these costs would be dependent upon the number of such patients moved, as well as the relative rates of the nursing homes and hospitals involved.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sSB 233

AN ACT CONCERNING THE DISCHARGE OF PATIENTS FOR NONPAYMENT OF APPLIED INCOME.

SUMMARY:

This bill allows nursing homes, to the extent federal law permits, to discharge or transfer a Medicaid patient whose "applied income" payment is 60 days or more overdue. The bill requires homes to give each patient who has applied for Medicaid written notice of (1) the estimated amount he or she will have to pay in applied income and (2) a statement that failing to pay this amount may lead to their discharge or transfer. Patients must acknowledge receipt of this notice in writing. Homes must use the Social Services Department's (DSS) method for calculating applied income.

Current law permits homes to discharge only self-pay patients for nonpayment. It permits homes to discharge Medicaid or self-pay patients only if (1) the home cannot adequately take care of the patient, (2) the patient's health has improved to the extent he or she no longer needs nursing home care, (3) the patient is dangerous to other patients' health or safety, or (4) the home closes. But the law prohibits discharging or transferring any patient if it is medically contraindicated.

EFFECTIVE DATE: October 1, 2010

BACKGROUND

Applied Income

"Applied income" is portion of a patient's monthly earned and unearned income (e.g., Social Security or pension benefits) DSS calculates the patient must pay the home after it determines he or she is eligible for Medicaid. DSS determines the applied income amount by

subtracting from the patient's income a personal needs allowance for use in the home; incurred medical expenses such as Medicare premiums; and, as appropriate, an amount to maintain a spouse in his or her home. DSS pays the difference between the applied income and the nursing home's Medicaid rate.

Federal Law on Discharge of Medicaid Patients

Federal regulations permit a nursing home to discharge a resident who "has failed to, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid (42 CFR 483.12(a)(2)(v))."

Nursing Home Discharge Process

Before a nursing home can discharge or transfer a patient it must, with the patient's or the home's doctor and other home staff, develop a discharge plan. The plan must outline the kinds of services the patient needs, evaluate the potential effects of the discharge on the patient, and state recommended actions to minimize those effects. If the discharge or transfer is involuntary, the home must give the patient, his or her representatives and personal doctor (if the home's medical director prepared the plan) a copy of the plan at least 30 days before the discharge date.

Between 30 and 60 days before it can discharge or transfer a patient, a nursing home must notify the patient or the patient's relative, guardian, or conservator in writing of (1) the discharge or transfer date, (2) the reasons for it, (3) where the patient is to go, and (4) these parties' right to appeal and the procedures for doing so. The parties have 10 days from receiving this notice to appeal to DSS. DSS must hold a hearing between 10 and 30 days after receiving this request and make a decision on it within 60 days after the hearing ends or 90 days from receiving the request for the hearing. Either party can appeal DSS's decision to Superior Court (CGS § 19a-535).

COMMITTEE ACTION

Select Committee on Aging

Joint Favorable Substitute Change of Reference
Yea 8 Nay 3 (03/11/2010)

Public Health Committee

Joint Favorable
Yea 30 Nay 1 (03/24/2010)